MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

516 09130

Reg. Dist. No. 190

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Howard

City or town: Elkridge (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 6204 Old Washington Boulevard

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Howard

City or town: Elkridge (If outside city or town limits, write RURAL and give nearest town)

Street No.: 6204 Old Washington Road (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: George W. Baldwin

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Married

6.(b) Name of husband or wife: Eva C. Baldwin

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): January 10, 1861

8. AGE:

Years	Months	Days	If less than one day
86	9	7	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Retired - Post Office

11. Industry or business

FATHER

12. Name: John T. Baldwin

13. Birthplace: Maryland

MOTHER

14. Maiden name: Sarah A. Bryan

15. Birthplace: Maryland

16. Informant: Sophia Owen

Address: Elkridge, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 10/20/47 (month) (day) (year)

Cemetery or crematory: Grace Episcopal Church Cemetery

Location: Elkridge, Maryland

18. Funeral director: Wm. Cook, Inc.

Address: 1217 St. Paul Street

19. Oct 18 1947 (Date rec'd by registrar) A. M. Heinel Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 17, 1947, at 3:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1943 to Oct 17 1947 and that I last saw him alive on Oct 16 1947

Immediate cause of death	DURATION
carcinoma of prostate	2 yrs
Due to: Myocardial Insufficiency	6 mos
Due to: Bronchopneumonia	1 mo
Other conditions: Generalized arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: carcinoma of Prostate Date of op. 2 mos

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Elkridge Md Date signed 10/17/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09131

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH:
County Howard
City or town Hoods mills
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 yrs
Hospital, Institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State Maryland County Howard
City or town Hoods Mill
(If outside city or town limits, write RURAL and give nearest town)
Street No. Hoods Mill Road
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Jerry Barber

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Mal	Black	Single

6.(b) Name of husband or wife —
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years 72 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Unknown (Town, county, and state)
10. Usual occupation Farm laborer
11. Industry or business Farm

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden name Unknown
15. Birthplace

16. Informant Howard Co. Welfare
Address Ellicott City

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10 (month) 4 (day) 47 (year)
Cemetery or crematory St Stephens
Location Elkridge Md.

18. Funeral director H C Neimeyer
Address Ellicott City Md

19. Oct. 4, 19 47 (Date rec'd by registrar) John B. Langhaus Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 2 19 47 ? M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 4 19 47 to October 4 19 47
and that I last saw h alive on at noon 19
Immediate cause of death Coronary disease — DURATION 1 hour.
Due to —
Due to —
Other conditions —
(Include pregnancy within 3 months of death)
Major findings of operations —
Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE Alpha M Herbert MD
DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY M. D. or other
Address Ellicott City Md Date signed 10.4.47

VS A15 9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09132

Reg. Dist. No. 191

1. PLACE OF DEATH:
County: HOWARD COUNTY
City or town: RURAL ELLICOTT CITY
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? SINCE MARCH 15th 47
Hospital, Institution, or street address where death occurred:
PINEL CLINIC ELLICOTT CITY
How long in hospital or institution? SINCE MARCH 15th 47

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: WASHINGTON D.C. County:
City or town: WASHINGTON.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5425 CONNECTICUT AVE
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: MARY ARMSTRONG BROADBENT

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED

6.(b) Name of husband or wife: HOWARD MILES BROADBENT
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): JAN 17th 1873

8. AGE: Years	Months	Days	If less than one day
74	9	24	..... hrs. ..... min.

9. Birthplace: NEWTON STEWART SCOTLAND
(Town, county, and state)
10. Usual occupation: HOUSE WIFE
11. Industry or business:

FATHER
12. Name: ROBERT ARMSTRONG
13. Birthplace: SCOTLAND

MOTHER
14. Maiden name: ~~STOREY~~ JANET ~~JANET~~ STOREY
15. Birthplace: SCOTLANT

16. Informant: MR JOHN H BROADBENT
Address: 5017 WETHERDSVILLE BALTO

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 15 1947 (month) (day) (year)
Cemetery or crematory: Arlington Natl Cem.
Location: Arlington Va.
18. Funeral director: Easton Sons
Address: Ellicott City, Md.
19. Oct 13, 1947 (Date rec'd by registrar) John B. Loughran Per. B.E.L. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 11th 19 47, at 8 45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MARCH 15th 19 47, to OCTOBER 11th 19 47
and that I last saw h.. alive on OCTOBER 11th 19 47

Immediate cause of death	DURATION
CEREBRAL HEMORRHAGE	3 DAYS
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

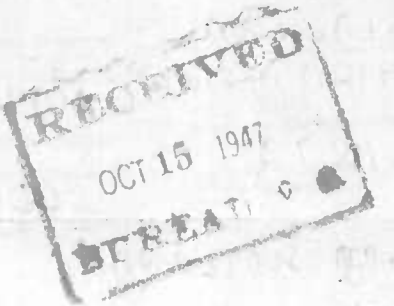
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place. (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Helen T. [illegible] M.D.
M. D. or other
Address: Ellicott City Md. Date signed 10/11/47

VS A15 9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING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OCT 15 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09133

Reg. Dist. No. 190

1. PLACE OF DEATH:
County: Howard
City or town: Rural - West Friendship
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Transient
Hospital, institution, or street address where death occurred: Route 40, 2 mi west of W. Friendship
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: [redacted]
City or town: Balto City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 908 Ridgely St
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Thomas E. Carroll

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Dorothy Carroll
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 21st 1915

8. AGE: Years	Months	Days	If less than one day
31	9	22	..... hrs. ..... min.

9. Birthplace: Balto Md
(Town, county, and state)
10. Usual occupation: Driver
11. Industry or business: Trucking
FATHER 12. Name: Charles W. Carroll
FATHER 13. Birthplace: Annapolis Md.
MOTHER 14. Maiden name: Annie M. Hess
MOTHER 15. Birthplace: Balto. Md.
16. Informant: Charles W. Carroll
Address: Furnace Branch Rd A.A.Co. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/16/47 (month) (day) (year)
Cemetery or crematory: U.S. National
Location: Balto. Md.
18. Funeral director: William Cook Inc.
Address: 127 St. Paul St
19. Oct 14 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 13 1947 at 5A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 13 1947 to Oct 13 1947
and that I last saw him alive on at no time 1947

Immediate cause of death	DURATION
Compound fracture of Skull	Inst.
Due to: Auto accident.	
Due to:	
Other conditions: Fracture of left shoulder	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 10-13-47
Where did injury occur? W. Friendship Howard Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Street
Means of injury Motor vehicle Injured at work? Yes

23. SIGNATURE: Alpha N Herbert M.D.
DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY M. D. or other
Address: Ellicott City Md Date signed 10-13-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45.15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09134

932

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH:
County Howard
City or town Ellicott City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Howard
City or town Ellicott City
(If outside city or town limits, write RURAL and give nearest town)
Street No. Columbia Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Charles E Dorsey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	C	W Widower

6.(b) Name of husband or wife Sarah Dorsey
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE:

Years	Months	Days	If less than one day
70	?	?	hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Farm Laborer

11. Industry or business

MOTHER FATHER
12. Name unknown
13. Birthplace "
14. Maiden name "
15. Birthplace "

16. Informant Chas. Dorsey
Address Ellicott City Md.

17. Burial Date thereof 10-13-47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Locust Chapel
Location Arbutus Md.

18. Funeral director H C Higinbotham
Address Ellicott City Md

19. Oct. 10, 1947 John B. Leyghman Pro. R. E. D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 9 1947 at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 9 1947 to October 9 1947
and that I last saw h[illegible] alive on at noon 1947

Immediate cause of death Arteriosclerotic Cardio Vascular Disease — DURATION 5 yrs.
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Alpha N Herbert M.D.
DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY M. D. or other
Address Ellicott City Md Date signed 10-9-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

09135

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH:
County: Howard
City or town: Ellicott City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Columbia Pike
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Howard
City or town: Ellicott City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Columbia Pike
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Elmer G. Due

3.(b) Social Security Number: 212-07-0627

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary E. Miller Due
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 1, 1893

8. AGE: Years	Months	Days	If less than one day
54	4	2	..... hrs. ..... min.

9. Birthplace: Baltimore Md.
(Town, county, and state)
10. Usual occupation: Insurance
11. Industry or business: New Amsterdam Casualty
FATHER 12. Name: John C. Due
FATHER 13. Birthplace: Denmark
MOTHER 14. Maiden name: Amanda C. Thomas
MOTHER 15. Birthplace: Baltimore Co. Md.
18. Informant: Mrs Mary E. Due
Address: Columbia Pike Ellicott City
17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 6, 1947 (month) (day) (year)
Cemetery or crematory: Druid Ridge Cemetery
Location: Pikesville, Md.
18. Funeral director: Easton Sons
Address: 608 Frederick Ave. Catons. Md.
19. Oct 5 1947 (Date rec'd by registrar) John B. Langhans Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 3, 1947, at 2:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 1947, to Oct 3 1947
and that I last saw h... alive on Oct 3 1947

Immediate cause of death	DURATION
Coronary Occlusion	Minutes
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: Ellicott City Md. Date signed 10/3/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932 09136

Reg. Dist. No. 103

1. PLACE OF DEATH:
County Howard
City or town Daisy
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Howard
City or town Daisy
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Eileen Morgan Hardesty

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Colored	Married

6.(b) Name of husband or wife: Mable Hardesty
6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): May 22 1887

8. AGE: Years 58 | Months 3- | Days 5- | If less than one day: hrs. min.

9. Birthplace: Howard Co
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Samuel Hardesty
13. Birthplace: Howard Co

MOTHER
14. Maiden name: Rebecca Randle
15. Birthplace: Howard Co

16. Informant: Mable H. Hardesty
Address: Woodbine

17. Buried (Burial, cremation, or removal. Which?) Date thereof Oct 20 1947 (month) (day) (year)
Cemetery or crematory: Daisy
Location: Daisy Howard Co
18. Funeral director: H. M. Snyder
Address: Mt. Airy

19. 10/28/1947 (Date rec'd by registrar) E. Earl Spencer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Oct 27 - 1947 at 6.45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-6-47 to 10-27-47
and that I last saw h... alive on 10-27-47

Immediate cause of death: Cerebral Hemorrhage, 2 days
Due to: Hypertensive Asteriosclerotic Heart Disease
Other conditions:

DURATION

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. H. Maloney M.D.
M. D. or other
Address Catonsville Md Date signed 10/27/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09137

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 193

1. PLACE OF DEATH:

County: Howard

City or town: Glenwood (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Howard

City or town: Glenwood (If outside city or town limits, write RURAL and give nearest town)

Street No. Woodbine P.O. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Albert Heyniller

3.(b) Social Security Number

4. Sex	5. Color of race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Nettie Lueker

6.(c) If alive, give age ..... years

7. Birth data of deceased (mo., day, yr.): Jan. 1, 1877

8. AGE:	Years	Months	Days	If less than one day
✓	69	9	26	..... hrs. ..... min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER — 12. Name: Nathan Heyniller

13. Birthplace: Md.

MOTHER — 14. Maiden name: Sarah Warner

15. Birthplace: Md.

16. Informant: Mrs. Nettie Heyniller

Address: Woodbine, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 29 1947 (month) (day) (year)

Cemetery or crematory: Greenfield Cemetery

Location: Sykesville, Md.

18. Funeral director: C. Harry Warner

Address: Sykesville, Md.

19. Oct 28 1947 (Date rec'd by registrar) E. Paul Dyson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: October 27 1947, at 12:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 13 1946, to October 27 1947 and that I last saw him alive on October 25 1947

Immediate cause of death: Cerebral hemorrhage — DURATION: 4 days

Due to: Arteriosclerotic cardiovascular disease — 10 years

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James P. Kerr M.D. M. D. or other

Address: Woodbine, Md. Date signed: 10/27/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

55e

09138

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: Howard

City or town: Relay

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred: 1720 Arlington Ave.

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Howard

City or town: Relay

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1720 Arlington Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME: WALTER PERKINS

3.(b) Social Security Number: 218-07-7900

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widower

6.(b) Name of husband or wife: Allie Perkins

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 29, 1865

8. AGE: Years	Months	Days	If less than one day
82	3	7	..... hrs. ..... min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual occupation: Factory Supt.

11. Industry or business: Davis & Hemphill

FATHER — 12. Name: Wm. W. Perkins

FATHER — 13. Birthplace: Elkridge, Md.

MOTHER — 14. Maiden name: Sara E. Christie

MOTHER — 15. Birthplace: Chesapeake City, Md.

16. Informant: Mr. W. E. Perkins

Address: 114 St. Dunstan's Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/9/47 (month) (day) (year)

Cemetery or crematory: Loudon Park Cem.

Location: Baltimore, Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 10-9 19 47 (Date rec'd by registrar) D. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Oct 6 1947, at P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1947, to Oct 6 - 1947 and that I last saw him alive on Oct 5 1947

Immediate cause of death	DURATION
Broncho pneumonia -	
Due to Carcinoma of Cachexia	Several weeks
Due to Epidermoid Sarcoma - origin	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of ~~operation~~ biopsy

Epidermoid Sarcoma - metastatic Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Frederick Becker M. D. or other

Address: 723 Medical Arts Bldg. - Balto. Md. Date signed: 10-8-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09139

83a

BC

Reg. Dist. No. 191

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County HOWARD

City or town RURAL - ELLICOTT CITY (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? SINCE 9-11-47

Hospital, Institution, or street address where death occurred: PINEL CLINIC

How long in hospital or institution? SINCE 9-11-47

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State MARYLAND County BALTIMORE CITY

City or town BALTIMORE (If outside city or town limits, write RURAL and give nearest town)

Street No. 219 W. MADISON STREET (If rural, give LOCATION)

2.(a) If veteran, name war /

3.(a) FULL NAME FANNIE C. T. SHAW

3.(b) Social Security Number 218-03-2887

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	Divorced - E

B.(b) Name of husband or wife –

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) ~~NNNNNNNN~~ Nov. 25, 1880

8. AGE:

Years	Months	Days	If less than one day
66	10	19	..... hrs. ..... min.

9. Birthplace BALTIMORE ? MD (Town, county, and state)

10. Usual occupation ACCOUNTANT

11. Industry or business

FATHER 12. Name Henry Trax

FATHER 13. Birthplace Md.

MOTHER 14. Maiden name Unknown

MOTHER 15. Birthplace

16. Informant MR HUGH B TRUITT

Address 231 ST. PAUL PLACE BALTO

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/16/47 (month) (day) (year)

Cemetery or crematory Greenmount Cem.

Location Balto., Md.

18. Funeral director WM. J. TICKNER & SONS

Address Balto., Md.

19. Oct. 15 1947 H. W. Hedrick Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH OCTOBER 14th 1947, at 4:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from SEPTEMBER 11th 1947, to OCTOBER 14th 1947

and that I last saw her alive on OCTOBER 14th 1947

Immediate cause of death	DURATION
CEREBRAL HEMORRHAGE	4 DAYS
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Helmut Frager MD M. D. or other

Address Ellicott City Md Date signed 10/14/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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09140

CERTIFICATE OF DEATH

Reg. Diat. No. 74 192

1. PLACE OF DEATH:

County. Howard

City or town. Rural - Lykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 69 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Howard

City or town Rural - Lykesville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George Arthur Thomas

3.(b) Social Security Number

4. Sex	5. Color or race	6.(d) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Maggie E. Edmondson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 30, 1878

8. AGE: Years	Months	Days	If less than one day
69	2	13	..... hrs. ..... min.

9. Birthplace Md. (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Agriculture

FATHER 12. Name James W. Thomas

FATHER 13. Birthplace Md.

MOTHER 14. Maiden name Alcesta Harding

MOTHER 15. Birthplace Md.

16. Informant Mrs. Maggie E. Thomas

Address Lykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 15, 1947 (month) (day) (year)

Cemetery or crematory Springfield Cemetery

Location Lykesville, Md.

18. Funeral director C. Harry Wees

Address Lykesville, Md.

19. Oct 14 1947 (Date rec'd by registrar) C. Harry Wees Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH October 13 1947, at 1 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1947, to Oct 13 1947

and that I last saw h alive on Oct 12 1947

Immediate cause of death Malignancy - Cancer

	DURATION
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. B. Barnes M.D. M. D. or other

Address Lykesville Md. Date signed 10/14/47

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09141

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CERTIFICATE OF DEATH

Reg. Dist. No. 195

1. PLACE OF DEATH:

County: Howard

City or town: North Laurel -
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Sparrows Point
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Julia Belle Watts

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: William Edward Watts

6.(c) If alive, give age: 81 years

7. Birth date of deceased (mo., day, yr.): October 16, 1867.

8. AGE: Years: 79 | Months: 11 | Days: 17 | If less than one day: hrs. min.

9. Birthplace: Shepardstown Va
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Joseph Stumps
13. Birthplace: Virginia

MOTHER
14. Maiden name: Belle Allison
15. Birthplace: Virginia

16. Informant: Alevia Phelps
Address: Dorsey, Maryland

17. (Burial, cremation, or removal. Which?) Burial Date thereof: Oct 6, 1947 (month) (day) (year)

Cemetery or crematory: Meadow Ridge Cemetary

Location: Dorsey, Maryland

18. Funeral director: DeWitt Donaldson

Address: Laurel, Maryland

19. October 5 1947 (Date rec'd by registrar) Fred E. Shipley M.D.M. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10 3 1947 at 10:15 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1-10 1947 to 10 3 1947 and that I last saw h-r alive on 10 3 1947

Immediate cause of death	DURATION
Hypostatic Pneumonia	3 da.
Due to: Myocardial Insufficiency	8 mo.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: B P Warn M. D. or other

Address: Laurel Md Date signed: 10 3 47

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.